STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E183	A. BUILDING _____ B. WING _____	C 11/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOVE COUNTY MEDICAL CENTER LTCU	PO BOX 129 QUINTER, KS 67752

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F 000	INITIAL COMMENTS The following citation represent the findings of complaint investigation #80823.	F 000		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This Requirement is not met as evidenced by: The facility had a census of 31 residents. The sample included 3 residents, who were reviewed for side rail use. Based on observation, record review and interview the facility failed to: Adequately assess for the use of side rails for 1 of 3 sampled residents (#1), who caught his/her arm in the side rail during a fall from bed and had injuries. The facility failed to assess for the safe use of electric bed controls for 3 of 3 residents. (#1, #2, and #3) Findings included: - Resident #1's admission (MDS) Minimum Data Set assessment, dated 10/29/14, indicated the resident had short and long term memory problems with moderately impaired decision making skills. The MDS also indicated the resident required extensive assistance with bed mobility and transfers and had impaired balance. The MDS further indicated the resident had a history of falls and had no restraints.	F 323		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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The 10/17/14 admission care plan directed 2 staff to assist the resident with transfers. Continued review of the care plan revealed no documentation to direct the staff for the use of the resident's side rails.

The 10/17/14 fall risk assessment indicated the resident was a fall risk due to confusion, poor safety awareness, impaired balance, limited mobility and a history of falls.

The 10/17/14 side rail assessment indicated the facility's interdisciplinary team had not recommended the resident have side rails on his/her bed.

The 10/17/14 at 4:29 PM, nurse's note indicated the resident required 2 staff to assist with his/her transfers and the resident preferred to spend most of the his/her time in bed.

The 10/18/14 at 9:10 AM, nurse's note indicated the staff found the resident on the floor next to his/her bed and the resident had a 4 (cm) centimeter by 2 cm skin tear on his/her right upper arm. The nurse's note further indicated the resident had been seated on the edge of his/her bed eating breakfast prior to the fall.

The 10/18/14 at 11:37 AM, nurse's note indicated hospice applied an air mattress to the resident's bed.

The 10/21/14 at 3:52 PM, nurse's note indicated the resident had a non-injury fall from his/her bed.

The 10/25/14 at 4:31 AM, nurse's note indicated the staff found the resident on the floor next to his/her bed with his/her arm wedged between the

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side rail and the mattress. The nurse's note indicated the resident required 2 staff to remove his/her arm from the side rail. The nurse's note further indicated the resident had numerous areas of bruising and redness on his/her right arm.

Review of the resident's medical record revealed no documentation to direct the staff to utilize the resident's side rails. Continued review of the resident's medical record revealed no documentation the facility assessed the resident's bed for safety after the staff applied the air mattress to the resident's bed.

The 10/25/14 at 2:46 PM, nurse's note indicated the staff notified hospice the resident had a fall with injuries. The nurse's note also indicated the staff informed hospice the resident's air mattress did not fit the resident's bed properly and there was a 4 inch gap between the air mattress and side rail.

The 10/25/14 fall investigation indicated the staff assessed the resident to have the following injuries after his/her fall from bed and getting his/her arm caught in the side rail:
1) 4 cm bruise on right upper and outer arm
2) 6 cm reddened area and bruising on right inner elbow
3) abrasion on jaw bone
4) 1 cm skin tear on right inner wrist

On 11/19/14 at 10:37 AM, observation, during initial tour, revealed 13 residents resting in bed. Continued observation revealed all the residents had side rails with electric bed controls up on their beds.

On 11/19/14 at 11:37 AM, Nurse C stated the

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staff assessed all the residents for the use of side rails and all the residents had side rails raised on their beds, due to the electric bed controls located on the quarter side rails. Nurse C stated the facility's side rail assessment had not directed the staff to assess for gaps in the side rails or between the side rail and mattress and/or assess if the residents could safely operate the bed controls.

On 11/20/14 at 9:22 AM, Nurse D stated the resident was cognitively impaired with a poor memory and required extensive assistance with transfers. Nurse D stated the side rails were raised on the resident's bed and he/she was not aware if the resident was able to use the bed controls. Nurse D further stated all the residents had side rails raised on their beds to access the bed controls.

On 11/20/14 at 9:27 AM, Nurse Aide A stated all the residents had the quarter side rails on their beds due to the bed controls on the side rail. Nurse Aide A stated not all the residents were able to use the bed rails to assist with bed mobility and/or operate the bed controls, but staff used the bed controls while providing cares for the residents.

On 11/20/14 at 9:42 AM, Nurse Aide B stated the resident was confused, had a poor memory and required extensive assistance with transfers. Nurse Aide B stated the resident had several falls from bed and was unable to operate the bed controls on his/her side rails Nurse Aide B further stated all the residents had the side rails with bed controls on their beds and staff operated the bed controls as needed.

On 11/20/14 at 10:21 AM, Nurse E stated the

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admission side rail assessment directed the staff to not use side rails for the resident, but staff had implemented the resident's bed rails. Nurse E stated the staff had not reassessed the resident's bed for side rail safety after the air mattress had been applied to the resident's bed. Nurse E further stated all the residents in the facility had side rails on their beds, due to the bed controls located on the side rail and the staff had not assessed for gaps in the side rails and/or the safe operation of the bed controls.

The facility had no side rail policy to direct the staff to adequately assess and safely apply side rails for the residents to use for bed mobility and transfer assistance. The facility had no policy directing the staff to adequately assess the resident's ability to use the electronic bed controls in a safe manner.

The facility failed to adequately assess for the safe use of side rails for Resident #1, who caught his/her arm in the side rail during a fall from bed and had injuries.

- On 11/19/14 at 10:37 AM, observation, during initial tour, revealed 13 residents resting in bed. Continued observation revealed all the residents had side rails with electric bed controls up on their beds.

On 11/19/14 at 11:37 AM, Nurse C stated the staff assessed all the residents for the use of side rails and all the residents had side rails raised on their beds, due to the electric bed controls located on the quarter side rails. Nurse C stated the facility's side rail assessment had not directed the staff to assess for gaps in the side rails or between the side rail and mattress and/or assess if the residents could safely operate the bed

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F 323	Continued From page 5 controls. On 11/20/14 at 9:22 AM, Nurse D stated all the residents had side rails raised on their beds to access the bed controls. On 11/20/14 at 9:27 AM, Nurse Aide A stated all the residents had the quarter side rails on their beds due to the bed controls on the side rail. Nurse Aide A stated not all the residents were able to use the bed rails to assist with bed mobility and/or operate the bed controls, but staff used the bed controls while providing cares for the residents. On 11/20/14 at 9:42 AM, Nurse Aide B stated all the residents had the side rails with bed controls on their beds and staff operated the bed controls as needed. On 11/20/14 at 10:21 AM, Nurse E stated all the residents in the facility had side rails on their beds, due to the bed controls located on the side rail and the staff had not assessed the safe operation of the bed controls. The facility had no policy directing the staff to adequately assess the resident's ability to use the electronic bed controls in a safe manner. The facility failed to assess for the safe use of electric bed controls for 3 of 3 residents.	F 323		